The Difference Card

SUMMARY OF BENEFITS

Institute on Aging	Kaiser	7/1/2024 to	6/30/2025			
HMO Plan (California)						
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	KAISER BENEFIT			
	DEDUCTIBLE & COINSURA	NCE				
Qualified High Deductible Health Plan		No				
Deductible Accumulation Period		Calendar Year				
Family Deductible Accumulation Type		Yes				
In-Network Individual Deductible	Last \$500	First \$2,500	\$3,000			
In-Network Family Deductible	Last \$3,500	First \$2,500	\$6,000			
Out-of-Network Individual Deductible		No out of Network				
Out-of-Network Family Deductible						
Prescription Deductible Application		N/A				
Prescription Individual Deductible		Ne Dress visition De du stile le				
Prescription Family Deductible	No Prescription Deductible					
In-Network Coinsurance %	30%	0%	30%			
In-Network Individual Coinsurance Limit	\$3,000	\$0	\$3,000			
In-Network Family Coinsurance Limit	\$6,000	\$0	\$6,000			
Out-of-Network Coinsurance %						
Out-of-Network Individual Coinsurance Limit	No out of Network					
Out-of-Network Family Coinsurance Limit						
In/Out Network Cross Accumulation		No				
	PHYSICIAN SERVICES					
Primary Care Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Specialist Office Visit Copay	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Telemedicine Copay	No Charge					
Other (Chiro) Office Copay	N/A	N/A	N/A			
	PREVENIIVE CARE					
Preventive Care / Screening / Immunization		No Charge				
Diagnostic Test X-Ray	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$2,500	Deductible & Coinsurance			
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$2,500	Deductible & Coinsurance			
	PHARMACY					
Tier 1 RX Retail Copay		F007				
· · ·	\$25	50%	30% up to \$50			

	¢25	50%	30% up to \$50
Tier 1 RX Mail Order Copay	\$25	JU /o	30% up to \$50
Tier 2 RX Retail Copay	\$50	50%	30% up to \$100
Tier 2 RX Mail Order Copay	ψ00	5078	50% 0p 10 \$100
Tier 3 RX Retail Copay	\$125	50%	30% up to \$250
Tier 3 RX Mail Order Copay	ψτ20	5076	0070 0p 10 \$200
Tier 4 RX Retail Copay	\$75	50%	20% up to \$150
Tier 4 RX Mail Order Copay	N/A	N/A	N/A
	MAJOR MEDICAL SERVIC	ES	
Outpatient Surgery Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
Emergency Room Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
Emergency Medical Transportation	Remaining Charges	First \$2,500	Deductible & Coinsurance
Urgent Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
Inpatient Hospital Facility Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$2,500	Deductible & Coinsurance
Behavioral Health Outpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Behavioral Health Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Prenatal and Postnatal Care		No Charge	
Delivery and All Inpatient Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Home Health Care		No Charge	
Rehabilitation Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Habilitative Services	Remaining Charges	First \$2,500	Deductible & Coinsurance
Skilled Nursing Care	Remaining Charges	First \$2,500	Deductible & Coinsurance
Durable Medical Equipment	Remaining Charges	First \$2,500	Deductible & Coinsurance
Hospice Service		No Charge	
Family Multiplier	2	Mail C	Drder Multiplier 2
	Please have your provider swi	pe the Difference Card for	
All claims must be submitted within 3 months of the end of			
deductible accumulation period.	Primary Care & Specialist Swipe -	First \$2,500	Download
Terminated members must submit claims within 3 months		·	the Mobile App
the termination date.	Urgent Care Swipe -	·	to View
	Rx Swipe -	50%	and Land
Information on this document based on carrier SBC	Deductible Expenses -	Up to \$2500	Submit Claims scan this with
	Call 888.343.2110 wi		YOUR CAMERA



The Difference Card SUMMARY OF BENEFITS

Institute on Aging	United Healthcare	7/1/2024 to	6/30/2025
	Core PPO Plan		
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
	DEDUCTIBLE & COINSURA	NCE	
Qualified High Deductible Health Plan		No	
Deductible Accumulation Period		Calendar Year	
Family Deductible Accumulation Type		Embedded	¢0,500
In-Network Individual Deductible	Last \$500	First \$3,000	\$3,500
In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000
Out-of-Network Individual Deductible	\$10,500	\$0 \$0	\$10,500
Out-of-Network Family Deductible	\$21,000	\$0	\$21,000
Prescription Deductible Application	N/A		
Prescription Individual Deductible		No Prescription Deductible	
Prescription Family Deductible In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500
In-Network Family Coinsurance Limit	\$7,000	\$0 \$0	\$7,000
Out-of-Network Coinsurance %	\$7,000 50%	0%	50%
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500
Out-of-Network Family Coinsurance Limit	\$21,000	\$0 \$0	\$10,000
In/Out Network Cross Accumulation	φ21,000	No	φ21,000
	PHYSICIAN SERVICES		
Primary Care Office Visit Copay	\$ 0	\$30	\$30 Copay
Specialist Office Visit Copay	\$ 0	\$60	\$60 Copay
Telemedicine Copay		No Charge	
Other (Chiro) Office Copay	\$ 0	\$30	\$30 Copay
	PREVENTIVE CARE		
Preventive Care / Screening / Immunization		No Charge	
Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsurance
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$3,000	Deductible & Coinsurance
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$3,000	Deductible & Coinsurance
	PHARMACY	1 1131 \$6,000	
Tier 1 RX Retail Copay	\$10	\$0	\$10.00
Tier 1 RX Mail Order Copay	\$25	\$0	\$25.00
Tier 2 RX Retail Copay	\$35	\$O	\$35.00
Tier 2 RX Mail Order Copay	\$87.50	\$0	\$87.50
Tier 3 RX Retail Copay	\$70	\$0	\$70.00
Tier 3 RX Mail Order Copay	\$175	\$O	\$175.00
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0	\$10/\$150/\$250
Tier 4 RX Mail Order Copay	N/A	\$0	N/A
	MAJOR MEDICAL SERVI		
Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Room Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Medical Transportation	Remaining Charges	First \$3,000	Deductible & Coinsurance
Urgent Care Inpatient Hospital Facility Fee	\$0 Copay Bomaining Chargos	\$50 First \$3,000	\$50 Deductible & Coinsurance
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges Remaining Charges	First \$3,000	Deductible & Coinsurance
Behavioral Health Outpatient Services	\$0	\$30	\$30 Copay
Behavioral Health Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Prenatal and Postnatal Care		No Charge	
Delivery and All Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Home Health Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Rehabilitation Services	۲۵۱۱۵۱۱۱۱۹ ۲۰۱۵۱۹۵۶ ۲۵	\$30	\$30 Copay
Habilitative Services	\$0	\$30	\$30 Copay
Skilled Nursing Care	ہو۔ Remaining Charges	پرون First \$3,000	Deductible & Coinsurance
Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsurance
	Remaining Charges	First \$3,000	Deductible & Coinsurance
Hospice Service	Kernanning Charges	Ι ΙΙ3Ι ψυ,υυυ	

Family Multiplier

Please have your provider swipe the Difference Card for the following amounts: All claims must be submitted within 3 months of the end of the deductible accumulation period. Primary Care Swipe -Terminated members must submit claims within 3 months of Specialist Swipe the termination date. Urgent Care Swipe -All Out-of-Network Services are subject to the Deductible Deductible Expense Information on this document based on carrier SBC

2

Call 888.343.2110 with any questions.

\$30

\$60

\$50

Up to \$3,000

Mail Order Multiplie

Download

the Mobile App

to View

and

Submit Claims

2.5

SCAN THIS WITH

YOUR CAMERA

The Difference Card

SUMMARY OF BENEFITS

Institute on Aging	United Healthcare	7/1/2024 to	6/30/2025
	Select Plus PPO Plan		
TYPE OF VISIT	YOU PAY	DIFFERENCE CARD PAYS	UHC BENEFIT
	DEDUCTIBLE & COINSURAN		
Qualified High Deductible Health Plan		No	
Deductible Accumulation Period		Calendar Year	
Family Deductible Accumulation Type		Embedded	* 0.500
In-Network Individual Deductible	Last \$500	First \$3000	\$3,500
In-Network Family Deductible	Last \$4,000	First \$3,000	\$7,000
Out-of-Network Individual Deductible Out-of-Network Family Deductible	\$6,000 \$12,000	\$0 \$0	\$10,500 \$21,000
Prescription Deductible Application	φτ2,000	N/A	φ21,000
Prescription Individual Deductible			
Prescription Family Deductible	N	o Prescription Deductible	
In-Network Coinsurance %	30%	0%	30%
In-Network Individual Coinsurance Limit	\$3,500	\$0	\$3,500
In-Network Family Coinsurance Limit	\$7,000	\$0	\$7,000
Out-of-Network Coinsurance %	50%	0%	50%
Out-of-Network Individual Coinsurance Limit	\$10,500	\$0	\$10,500
Out-of-Network Family Coinsurance Limit	\$21,000	\$0	\$21,000
In/Out Network Cross Accumulation		0	
	PHYSICIAN SERVICES	¢20	¢20.0 are an i
Primary Care Office Visit Copay	\$0 \$0	\$30	\$30 Copay
Specialist Office Visit Copay	\$O	\$60	\$60 Copay
Telemedicine Copay	ф <u>о</u>	No Charge	
Other (Chiro) Office Copay	\$0 PREVENTIVE CARE	\$30	\$30 Copay
Preventive Care / Screening / Immunization		No Charge	
	DIAGNOSTIC PROCEDUR	ES	
Diagnostic Test X-Ray	Remaining Charges	First \$3,000	Deductible & Coinsurance
Diagnostic Test- Lab Bloodwork	Remaining Charges	First \$3,000	Deductible & Coinsurance
Imaging (CT/Pet Scans, MRIs)	Remaining Charges	First \$3,000	Deductible & Coinsurance
	PHARMACY		¢10.00
Tier 1 RX Retail Copay	\$10 \$05	\$0	\$10.00
Tier 1 RX Mail Order Copay	\$25	\$0	\$25.00
Tier 2 RX Retail Copay	\$35 \$97.50	\$0 \$0	\$35.00
Tier 2 RX Mail Order Copay Tier 3 RX Retail Copay	\$87.50 \$70	\$0 \$0	\$87.50 \$70.00
Tier 3 RX Mail Order Copay	\$70\$175	\$0 \$0	\$175.00
Tier 4 RX Retail Copay	\$10/\$150/\$250	\$0 \$0	\$10/\$150/\$250
Tier 4 RX Mail Order Copay	N/A	\$0 \$0	N/A
	MAJOR MEDICAL SERVIC	ES	14/7
Outpatient Surgery Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Outpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Room Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Emergency Medical Transportation	Remaining Charges	First \$3,000	Deductible & Coinsurance
Urgent Care	\$0 Copay	\$50	\$50
Inpatient Hospital Facility Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Inpatient Surgery Physician / Surgeon Fee	Remaining Charges	First \$3,000	Deductible & Coinsurance
Behavioral Health Outpatient Services	\$0	\$30	\$30 Copay
Behavioral Health Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Prenatal and Postnatal Care		No Charge	
Delivery and All Inpatient Services	Remaining Charges	First \$3,000	Deductible & Coinsurance
Home Health Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Rehabilitation Services	<u>\$</u> ∪ ¢⊃	\$30	\$30 Copay
Habilitative Services	\$0 Demoining Charges	\$30 First \$2,000	\$30 Copay
Skilled Nursing Care	Remaining Charges	First \$3,000	Deductible & Coinsurance
Durable Medical Equipment	Remaining Charges	First \$3,000	Deductible & Coinsurance
Hospice Service	Remaining Charges	First \$3,000	Deductible & Coinsurance
Family Multiplier	2		Mail Order Multiplie 2.5

All claims must be submitted within 3 months of the end of the

deductible accumulation period.

Terminated members must submit claims within 3 months of

the termination date.

All Out-of-Network Services are subject to the Deductible

Information on this document based on carrier SBC

Please have your provider swipe the Difference Card for the following amounts: Primary Care Swipe -\$30 Specialist Swipe -\$60 Urgent Care Swipe -\$50 Deductible Expense Up to \$3,000

Call 888.343.2110 with any questions.

and

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